Robert Drake, M.D., Ph.D.: Fixing the system

By Laura Stephenson Carter

It's a classic catch-22: About half of the people with serious mental illness also have a substance-abuse disorder, and about half of those with substance-abuse problems are also affected by mental illness. "Yet we have two separate treatment systems that don't serve the needs . . . of people who have co-occurring disorders," says DMS psychiatrist Robert Drake, M.D., Ph.D.

People with substance-abuse problems have been excluded from the mental-health system, he explains, and vice versa. "The poor patient who had two serious illnesses often got kicked out of both programs, or excluded from both programs, because of having the other disorder," Drake says. "In the rare situation where they were welcomed in both programs, the patient found it virtually impossible to go back and forth between two different providers and hear really different messages about how to get better."

"The poor patient with two serious illnesses [mental illness and a substance abuse disorder] often got excluded from both programs because of having the other disorder," Drake says.

In the mid-1980s, for example, an intoxicated person was not allowed in New Hampshire Hospital, the state's inpatient psychiatric facility, and people with substance-abuse problems were kicked out of mental-health housing programs and mental-health centers. The problem "has to do with a long history of having separate training tracks and treatment systems and funding streams and federal bureaucracies and state bureaucracies," explains Drake, not to mention "clinicians who don't talk to each other because they have different theoretical frameworks.

"It seemed clear to me," he says, "that that was an ineffective way to do things." As a result, he has devoted a significant part of his career to developing treatments for people dually diagnosed with mental-health disorders and substance-abuse problems.

The director of the New Hampshire-Dartmouth Psychiatric Research Center (NHDPRC) since 1987 and the holder of DMS's endowed Andrew Thomson Professorship in Psychiatry since 1993, Drake is nationally known for his work in evidence-based psychiatry. Evidence-based medicine is a movement to ensure that practice decisions are based not just on the subset of medical knowledge that a given practitioner may be aware of, but on a critical evaluation and systematic application of all available knowledge.

Drake has been principal or coprincipal investigator for dozens of grants, including projects on substance abuse in psychiatric patients and vocational rehabilitation for dual-diagnosis patients. He's published more than 280 journal articles, book chapters, books, and abstracts; received numerous awards; held leadership posts in national professional societies; and served on a number of editorial boards.

But he doesn't like taking all the credit for these accomplishments. "Sometimes when you're the oldest person around, you get all the attention," he says with Jimmy Stewart-like modesty. "I always worry, getting these awards and publicity, that . . . other people here who have done most of the work . . . don't get as much of the credit."

Drake didn't start out with the intention of becoming an evidence-based psychiatrist. He majored in biology at Princeton and entered Duke's M.D.-Ph.D. program planning to focus on neuropharmacology. But then he decided to do his Ph.D. in developmental psychology and figured he was headed for a clinical practice in developmental pediatrics. Yet after completing his internship in pediatrics at Duke and residency in psychiatry at Harvard's Cambridge Hospital, he realized he wanted to do more than treat patients.

As a resident, he says that he was always asking uncomfortable questions like: "Is there any evidence that this is helpful to people?" He was determined to figure out a way to answer such questions. He felt the mental-health profession needed "to develop more of a scientific base for what we were trying to do in terms of helping people to recover from mental illness."

Although he started his career as a clinician—first as codirector of ambulatory community services at Cambridge Hospital and then, from 1984 to 1990, as medical director of the DMS-affiliated West Central Community Mental Health Services—it wasn't long before he immersed himself in evidence-based research.

At the NHDPRC, Drake and his colleagues have developed treatment programs tailored to people with co-occurring disorders. Most places in the United States—and in much of the Western world, for that matter—still have separate systems for treating mental illness and substance abuse. "We've tended to see substance abuse through a moral lens—that it's . . . people being bad or choosing to do something reprehensible or a character problem," Drake says. "Actually, the evidence is that substance abuse is a biopsychosocial illness. . . . To the extent that we keep thinking about it as a moral or a religious problem rather than a medical problem, we'll keep having grossly underfunded services, and people with addictions will continue not getting much treatment in this country."

But thanks to Drake, "New Hampshire has been a leader in developing services for co-occurring disorders. We have visitors from all over the world who come here to see our centers," he says. And thanks to a gift a couple of years ago from the West Family Foundation, Dartmouth was able to establish the West Institute for the Implementation of Evidence-Based Practices. The West Institute provides training in the interventions developed by NHDPRC to doctors, social workers, and other mental-health center staff members.

Drake contends that treatment for co-occurring disorders, when done properly, has been quite successful. He has the data to prove it.

Laura Carter is the associate editor of Dartmouth Medicine *magazine.*

JON GILBERT FOX

DMS psychiatrist Robert Drake has pioneered the movement to develop effective treatments for those with "co-occurring" mental illness and substance abuse problems.

"We are involved in lots of treatment studies and two longitudinal follow-ups where we're following cohorts of these people for 10 years—one in New Hampshire and two at urban sites in Connecticut," he explains. "The outcomes are really dramatic. When . . . people with severe mental illnesses like schizophrenia and bipolar disorder get into abstinence, their risk for all sorts of negative outcomes goes down dramatically—for relapse, hospitalization, incarceration, violence, victimization, homelessness, family problems, HIV, hepatitis." In fact, he adds, "substance abuse negatively affects their lives in so many ways that the most effective thing we can do is help them get abstinent."

NHDPRC has documented "that the outcomes in these treatment programs are pretty good—50 to 60 percent of these people get stably abstinent over a few years and do really well," Drake observes. "So it's clear that substance abuse is a treatable condition for people with mental illness."

But that wasn't always so clear. "One of the things I learned when I was getting trained in substance abuse was that the more severe the psychopathology . . . the less treatable they were," Drake says. "But actually, the outcomes are very good in our treatment programs. You just have to go about it in a way so that the treatment is tailored for people who've got co-occurring disorders."

Achieving good outcomes, however, means first of all getting people into the programs. It turns out that "many of these people were so demoralized and so mistrusting of the health-care system, and so caught up by their addiction, that we couldn't get them to come into the mental-health center," Drake explains.

"So we started doing lots of outreach and meeting people in the streets and in homeless shelters and in jails, wherever they were, and trying to engage them in a relationship there. That was pretty effective because we could build a relationship with them and then once we had that relationship we could help them get on medications, get their symptoms under control so that they trust us more, come into the mental-health center and start going to groups."

There were other frustrations, too. Many of these people weren't motivated to pursue abstinence. "They were confused about the meaning of substance abuse in their lives, because their mental experience had been chaotic for a few years," says Drake. "If you hallucinate [or] have other horrible things happen to you, it's very hard to see the relationship between using substances and negative consequences."

Drake's team found that motivational counseling—a technique developed at the University of New Mexico—helped. The team also determined that patients with jobs and decent housing were more likely to be successful. "We struggled for 10 or 15 years figuring that out," Drake admits. Another technique the team has fine-tuned is family psychoeducationals interventions, so the patient's family understands and participates in the treatment process.

Under Drake's guidance, many mental-health centers have revamped their programs to accommodate dual-diagnosis patients. But "it's complicated," he says. "You need to change all the programs. . . . Our vocational programs, our housing programs, our emergency services programs, our family education programs, our medication programs . . . all of these have to be realigned or tailored so they address the needs of people who've got co-occurring disorders."

For example, vocational programs have proven successful when patients are assigned to appropriate jobs. "You can't be getting people jobs in restaurants where there's a lot of alcohol floating around. That doesn't make sense," says Drake. Placements in certain other industries—where there is likely to be drinking or drug-use on the job—are avoided, too. "Our clients . . . don't have very good skills for resisting social pressure," he notes. "It's better to place them in a job where everybody's abstinent."

And housing programs have had to be modified, too. "Typically, in mental-health housing, if people drink they get kicked out," Drake explains. "Well, that isn't going to work for people who've got dual disorders. Over the years we've developed techniques where you can set up some rules and reinforcements to help people move toward recovery, but you don't kick them out. So if somebody comes in who'd been drinking, we'd let them stay in their own apartment as long as their behavior is not a problem. But if they come in and they're disruptive and break the furniture or something, then they get moved out and

continued on page 71